DWS-UI
Form 615-CW
Rev. 8.97

WORKERS COMPENSATION

UTAH DEPARTMENT OF WORKFORCE SERVICES

STATEMENT REGARDING CLAIMS FOR BENEFITS

Claimant's Name _____ Social Security No. _____

Reference (Enter type and date of claim): _____

Date of work-related injury or illness: MO _____ DAY _____ YEAR _____

What was your injury or illness? _____

City/State where you were working when you were injured: _____

Were you paid Worker's Compensation? YES [ ] NO [ ]

If YES, please complete the following:

From what state were benefits paid? _____

Name of insurance company: _____

Adjustor's name: _____

Adjustor's phone number: _____

Your file number: _____

Dates paid Worker's Compensation: from _____ to _____

Type of compensation (circle one):

Temporary Total/ Permanent Partial/ Other

Date released by doctor to return to full-time work: _____

(If your release date is more than 90 days ago, explain why you did not file until now): _____

_____

_____

Do you have physical restrictions which affect your ability to work full-time?

YES [ ] NO [ ] (If YES, please explain): _____

Have you contacted your former employer since your release? YES [ ] NO [ ]

Why aren't you working there now? _____

_____

FOR PRIVACY ACT SEE UNEMPLOYMENT INSURANCE CLAIMANT GUIDE

I know that the law provides penalties for falsifying statements in order to obtain benefits. I certify that the above statements are true and correct to thebest of my knowledge and belief.

Signed By: _____

Representative: _____ Date Signed: _____